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ABSTRACT

Published for secondary school youth in England, the PROBE series presents provocative information and discussion questions on topical themes. The focus of this issue is on aspects of medicine which raise moral dilemmas for doctors, patients, and society in general. This issue contains case studies which illustrate ethical questions raised by the changing role of medicine in society. For each case study, a review of medical practice and issues is followed by discussion questions for students. Legalization of abortions under special circumstances has prompted debate over the status of the fetus and a mother's rights to terminate a pregnancy. Practices of artificial insemination by donor raise questions concerning the donor's right to maintain interest in his child, the mother's motivation, and the "social father's" ability to accept as his own a child whom he did not father. Research on embryo transfers prompts concerns about political manipulation of the process if it is perfected in humans. Issues about euthanasia include a person's right to die with dignity and who has the right to decide if a patient should die. Organ transplants can be life-savers for critically ill people, but when too few donors exist, who should decide which patients will receive donated organs? A concluding section reviews critical questions such as how the interests of the individual relate to those of society, and how medicine should progress. (AV)

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probe

Dilemmas in Medicine

2nd Edition 1977

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PROBE is published by C.E.M. as part of its service to Secondary Education and the Youth Service. It presents in a provocative form information and discussion material on a topical theme aiming to open areas for further discussion. The views presented by the author are not necessarily shared by the Series Editor or by C.E.M. as a whole.

About the subject matter of this PROBE there are strongly conflicting views; about its underlying importance for the rising generation there can be little disagreement. Growing up into the modern world means facing the questions considered here, and this PROBE is offered as a tool to help the processes of thought necessary in judging for oneself among the various beliefs and values in this controversial field.

MARGARET HALSEY has written this revised edition. She has an honours degree in Biology from Edinburgh and has specialised in Genetics. At present she is C.E.M. Secretary for the Midlands and helps to organise the C.E.M. National Students' Committee and to edit their magazine, SCAN.

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INTRODUCTION

"Scientist claims fertilisation of egg in test-tubes."

"Doctors announce new cure for disease X".

"Man kept alive for 56 days despite heart failure".

These and many other headlines are to be found with increasing frequency in today's papers. Progress in developing medical techniques is an accepted part of life. Some aspects are regarded with suspicion, others acclaimed with jubilation - but all affect our quality of life - and that of the whole community.

Scientific advance has created technical problems - "When does life begin?" "How far can it be changed?" "Can it be prolonged?" But the advance of science has also raised moral and ethical questions. "What is the value of human life?" "Who has the right to control another's development?" "What should be our attitude to suffering?" "How should decisions be made?" These and many other questions face doctors and patients today.

This PROBE looks at some aspects of medicine and shows how these aspects raise moral dilemmas. It suggests questions which are appropriate to ask when making our own decisions about moral issues.

Firstly the publication examines the areas of

birth
life
and death,

and some specific problems for the community in these areas. No attempt is made to deal with all the problems in such a wide field. The case studies have been chosen to illustrate the ethical questions raised by the changing place of medicine in society. In the final sections it examines some ethical issues related more generally to the changing place of medicine in society.

BIRTH

Recent discussion about changes in attitude to birth is two-sided. On the one hand, some are concerned about the effects of legalising abortion; on the other, some are worried about scientific research to improve the lot of infertile couples. Both these raise different kinds of ethical questions.

Abortion

> Mrs. X was pregnant with her fifth child and was finding it hard to manage. She had been told that the birth of a fifth child might seriously endanger her life . . . .
>
> Miss Y slept with her boyfriend after a party. At 17 she had little previous sexual experience and when she found she was pregnant, she was too scared to tell her parents . . . .
>
> Mrs. Z was 6 weeks pregnant when she contracted German measles. If her child was born it might well be blind . . . .

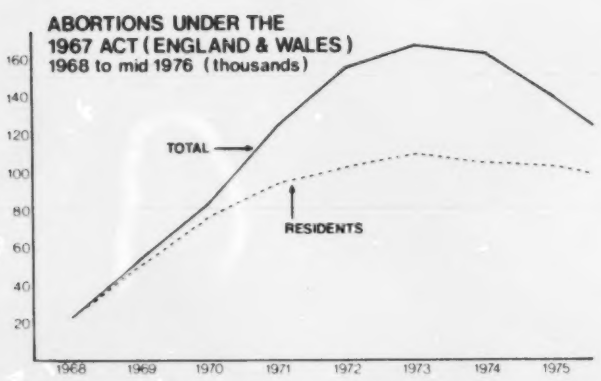
These are three examples of people who might decide that they wanted their pregnancy terminated. The first, because the mother's life would be endangered, the second because the mother did not want and probably could not cope with a child, the third because the life of the child might be endangered. Obviously these three cases raise different kinds of ethical questions.

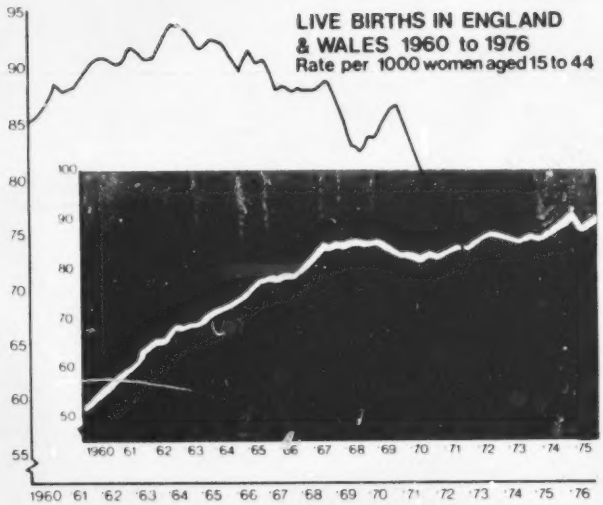
WHAT IS THE LAW?

The passing of the Abortion Act in 1967 reflected a considerable change in opinion about abortion in Britain. Prior to this abortion was regarded as a criminal offence in England and Wales, with the possibility of life imprisonment for those found guilty.

At the time of going to press, May 1977, there is considerable discussion in Parliament about the possible "tightening up" of this law as many people feel that it is open to too loose an interpreation. However, at present the law as it stands makes the following requirements:

> "The Abortion Act (1967) provides that:
> A person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith:
> i. that continuation of the pregnancy would endanger the life of the pregnant woman or
> ii. that continuation of the pregnancy would involve risk to the physical or mental health of the pregnant woman greater than if the pregnancy was terminated or





iii. that continuation of the pregnancy would involve injury to the physical or mental health of any existing children of the pregnant woman's family greater than if the pregnancy was terminated or

iv. that there exists a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped."

The Act also provides that "in determining whether the continuance of a pregnancy would involve such risk to the health of the pregnant woman or of her existing children, account may be taken of her actual or reasonably foreseeable environment".

The abortion must be performed by a registered doctor in a National Health Service Hospital or "approved place."

SOME IMPORTANT ETHICAL CONSIDERATIONS:

In thinking about the Law, one should also ask the question "What does this say about our attitude to the ethical issues around abortion. Do we consider a foetus alive? At what stage? These two more technical questions verge further on the ethical when we consider the questions "Is it right to take life and if so in what circumstances?" In order to explore ethical considerations fully we must consider the foetus, the mother and the doctor's conscience.

<u>The Status of the Foetus and the Future of the Child</u>. "Every child conceived has a right to live" is central to much traditional thinking about abortion. Why?

A. To interfere with this new life is to break the "natural law" of procreation.

B. This foetus is a person in its own right, it is more than a mere bundle of cells, it has a life of its own to destroy which would be murder. In addition much traditional and some modern theology would claim that the foetus has a soul infused by God who has a will and purpose for it to live and thus it should be allowed this right and be well cared for, not destroyed.

Against this argument, others might level the following criticisms :

A. Sexual intercourse has valuable functions other than those of creating children and the "natural law" can be interfered with in contraception methods. In a responsible society where people are able to plan pregnancies more effectively, abortion may be another safeguard against unwanted children.

B. The foetus cannot yet be considered human and thus its rights must fall subordinate to those of the mother.

Would you be
areful if
it was you that got pregnant?
Anyone married or single can get advice on contraception from the Family Planning Association.
Margaret Pyke House, 27-35 Mortimer Street, London W1 N 8BQ. Tel. 01-636 9135.

C. The future quality of life of the foetus must be considered. If it is likely to be malformed or if it is likely to live an unhappy unwanted existence, then its right to live must be modified in the light of the quality of its life.

THE RIGHTS OF THE MOTHER : A high percentage of abortions in Britain are granted to women on the grounds of possible detriment to the mental and physical health of the mother.

The definition of mental and physical health is a very wide one, putting great onus on the doctor to define what is meant by these terms. It also will depend on the relationship between doctor and patient, the ability of the mother to put over her case convincingly.

Those who oppose abortion may claim that this clause is open to wide abuse.

A. To uphold a mother's right to destroy her child may encourage greater promiscuity in a society which holds life cheap.

B. The mother might be "upholding her rights" only as a result of pressure from her family. This pressure would be increased if abortion were made easier.

Those who feel abortion is valid claim that :

Abortion is entirely an individual and personal matter. An individual's rights should not be sacrificed for the sake of a more moral society.

THE CONSCIENCE CLAUSE : "No person shall be under any duty to participate in treatment to which he has a conscientious objection" is the clause in the law providing for doctors who disagree with abortion on grounds of conscience. In practice this leads to doctors with strict principles refusing to perform abortions. Some may refer the matter to colleagues who are more likely to be sympathetic to the case, some may refuse to pass on the information. For the "patient" this may mean that she has to find a doctor who is more likely to be sympathetic to her wishes.

It is notable here that some areas of this country have more liberal attitudes than others. Many may seek private help rather than State help in such areas. In the past the phrase "back-street abortion" was used to describe illegally performed abortions, but there are no accurate figures to show us whether or not the number of these has declined since 1968.

WHO DECIDES : On the basis of these considerations, how are decisions to be reached? Who is the best person to make decisions about the future of another's life? Ideally, many people feel that decisions should not be taken quickly and several people such as family, social workers, etc., should be consulted. However, preganancy is often not diagnosed until

the second month, and the best time to perform an abortion is before the foetus is 12 weeks old and starts to take human shape. In America, Abortion Committees are popular, so decisions can be made objectively and prevent the doctor being pressurised by patients or relatives, but in Britain the decision rests ultimately with the doctor who is to perform the operation. His task is no easy one and obviously depends on a good relationship with his patient in which honesty, respect and compassion are of prime importance.

FOR DISCUSSION

1. Looking at the ethical considerations mentioned, how do you think that they apply to Mrs. X, Miss Y and Mrs. Z. In which case would you find it hardest to make a decision if you were a doctor?

2. "The doctor who does not wish to abort on grounds of conscience is put into a very difficult position by the abortion law".
Do you feel doctors should ever go against their conscience in this matter? If so, why and when?

3. "Mothers are not the best people to decide whether or not they should have abortions. Their decision is likely to be too subjective because of the different biological state of their body when they become pregnant".
Do you agree? Why?

4. "To obtain an abortion in private clinics can cost £150. Since these are often more liberal in interpreting the law than the National Health Service, it means that abortions are more readily available for the rich than the poor".
Would you change the law (if you were able) and how, to prevent this happening?

5. "The numbers of people coming into the country from outside to obtain abortions mean that our hospitals are not able to serve those with other needs effectively".
Do you feel that we should be granting abortions to those whose country's law is stricter than ours?

6. In October 1970 the Pope is quoted in the Times as saying, "Abortion has been considered homicide since the first centuries of the Church, and nothing permits it to be considered otherwise today . . . .".
Do you agree? If not what distinctions would you draw between abortion and homicide?

7. "The percentage number of abortions in proportion to live births is rising in the country. Abortion is all too readily looked on as a form of late contraception and this encourages an irresponsible attitude to parenthood."
Do you agree or disagree with the second sentence? Why? Are we too ready to take abortions for granted? Does this say anything about our fundamental attitudes to human life?

8. "People should be more ready to look at alternatives before they consider abortion".
Since there is a "shortage" of children for adoption, do you feel this possibility is too readily ruled out?

Overcoming Infertility

"Marriage was first ordained for the procreation of children."
This quotation from the Anglican wedding service reflects the feeling of a large number of people who see child-rearing as a central reason for marriage. But in Britain it is calculated that 10% of all couples are infertile and cannot produce children. Methods of changing this situation are at present being developed in Britain and, although we are far from the test-tube babies of Huxley's "Brave New World", scientific research and development is advancing in this area all the time.

There are two major ways of increasing fertility which we will consider here - by "artificial insemination by donor" and by "embryo transfer".

ARTIFICIAL INSEMINATION BY DONOR : Artificial insemination donation (AID) is a process used if a husband is infertile. Instead of a child being produced by the normal processes of sexual intercourse, semen from a fertile donor is injected into the woman's vagina at the time of ovulation when she is most fertile, and if the process is successful, fertilisation of the egg takes place and pregnancy begins. The process takes place in a limited number of clinics in Britain today and is estimated to have a 75% success rate. In America it was calculated that 6,000 live births resulted from AID in 1966.

The law covering this in Britain has the following requirements :

1. that the woman requiring AID should be older than 16 and should consent to AID in writing;
2. that there is no need for the husband to give his written consent;
3. that the donor sperm should be considered healthy by the doctor;
4. that the resulting child is considered illegitimate and may be registered for adoption when 6 weeks old. (As is the case with more regular forms of adoption).

One legal point of interest surrounds that of the status of the husband and some have suggested that AID might provide grounds for divorce if it takes place without the husband's consent.

MORAL PROBLEMS : Some moral questions that this raises are similar to those on abortion and relate to the people involved ;

The Mother. Those who oppose AID might argue that the motivation of the mother has to be carefully examined. Her desire to have a child may be selfish or a result of social pressure and may over-ride rational considerations of the kind of future the child is likely to have.

On the other hand, those who favour AID may argue that the joy given to a mother and father far outweighs this. Should some be doomed to a childless marriage when others can bear children freely? In an age where the numbers of children for adoption are falling this could be one responsible way of bringing children to a couple unable to have them.

The Husband (called the 'social' father.) For the husband of a woman who has undergone AID the situation is still more complex. He has to come to terms with his own infertility and the natural desire of his wife (and possibly himself to bear children. He has to accept the fact that an AID produced child will not be his but he will bear responsibility for fathering it.

Those who are against AID may argue that this places great strain on the integrity of a marital relationship, and that the strains placed on the social father may well mean that he is unable to accept the child as if it were his own, and accept the full responsibility of family life.

Those who favour AID may reply that although these strains are considerable, if a father has consented to AID, he has presumably faced up to these problems and thought them out rationally. Given a mature relationship between husband and wife, these difficulties can make their relationship firmer, deeper and in addition, bring them joy that they would not have expected previously.

The Donor. Several questions relate to selection of the donor, whether or not he is paid, and his motivation and interest in the child subsequently.

Those who feel AID is undesirable may cite the problems in donor selection of knowing his genetic history and assessing his "fitness". One London G.P. said on a BBC Television programme in 1972 that he paid donors according to their "genetic fitness" (how many "good" inheritable qualities they had!). In addition, should one prevent the donor from taking an interest in his child? What problems would this create both for the social relationships between the child and the family of which he is now part?

Many who favour AID are aware of these problems and feel this places great onus on the doctor to extract an accurate genetic history from the donor. Many feel that it is important that the donor's genetic characters should resemble those of the social father as closely as possible. If possible, the donor of the sperm should remain anonymous to avoid future embarrassment.

The Child. Critics of AID may argue that there is value in the uniqueness of each individual, and that the more selection of donors takes place, the less an individual is likely to feel he is unique. There is also the possibility of the technique being politically manipulated at the expense of the child. What effect is the knowledge of his or her background going to have on the child?

Those in favour of AID may argue that it is unlikely that in our society the process will be politically manipulated, and that individuality and feelings of value are as much an environmental as a genetic quality. They see that the situation has to be sensitively handled but argue that mature adults are well able to do this.

POSSIBLE FUTURE CHANGES : At the moment an AID child is registered at birth as illegitimate and although the process is not illegal, it tends to have an air of conspiracy about it. Those who accept that AID is desirable feel that this registration should be changed, and that if husband and wife have consented to the process one should replace the concept of "legitimacy" by "consent".

Scientists in Britain are well aware of the complex situation that could ensue if the process were commercially exploited, and many wish to press the government to legislate on the issue, preventing commercial exploitation.

In the USA human sperm have been stored in "sperm banks" at low temperatures for considerable lengths of time. Thus in theory, children could be 'fathered' by men long dead.

In order that the sperm used may be as accurately determined as possible, some have pressed for a "genetic register" of the donor's background - a register of his family history with regard to inheritable characteristics. Obviously this raises questions about confidentiality. Concern has also been voiced about the lack of control over the selection of the donor and his payment; and a recent report published by the British Association for the Advancement of Science said that this clearly needed to be changed. The changes cited are mainly legal ones, but it should be remembered that they reflect changes

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Medical dilemmas are also raised by the use of drugs for fertility, which have resulted in multiple births

in the understanding of fatherhood, and control of reproduction. It is changes in these conceptions which reflect the new moral dilemmas we are placed in today.

EMBRYO TRANSFER : The phenomenon of 'test-tube babies' is one which can be over dramatised by popular writing on the matter. But to say this does not imply that the question is not a serious one; it also implies that fact should be separated from fiction. Firstly we should see how far the technique has advanced, how widely it can be used, and then consider some of the ethical questions about the process.

WHAT IS THE PROCESS? : The process is one in which eggs are taken from the mother, are fertilised outside the mother's womb, and kept in culture to produce an 'embryo' the beginning of a child. It bypasses the proces of pregnancy in situations in which the mother is not for some reason able to produce children in the normal process.

The fertilised egg could potentially be transferred back to the original mother's womb or that of a foster mother who would bear the child on behalf of its real parents.

At present it is not known how far the process has gone. At a British Medical Association conference in July 1974, Professor F.R. Bevis claimed that he knew of eggs which had been fertilised outside the womb and then implanted. On another occasion, R.G. Edwards claimed to have cultured eggs outside the womb to the 16 cell stage, but not to have taken the process further. It is generally accepted that the process of fertilisation has been completed outside the womb but the process of reimplantation in humans has not.

ETHICAL QUESTIONS : The ethical questions this raises overlap with those of AID particularly with regard to the motivation of the mother, the feelings of the child, with effects on society and the possibilities of the process being manipulated politically. They also relate to the progress of scientific research, the relationships of the foster mother to the real mother of the child and the relationship of the mother to her child after the process is complete.

THE PROGRESS OF SCIENTIFIC RESEARCH : Here those who oppose embryo transfer might claim that those who practice it could well be more interested in the advancement of science than the feelings of a woman desperate to have a child.

Those in favour would claim that if the mother is well-informed about the potential risks in the process, then the situation is not so open to abuse. In addition they might argue that research will never progress unless people are willing to be self-sacrificial about their own situation for the good of future generations.

THE RELATIONSHIPS OF FOSTER MOTHER AND REAL MOTHER : Those opposing embryo transfer when the fertilised egg is fostered may argue that scientists have no right to expect a woman to go through the process of pregnancy and then give up a child at

the end of it. They may also say that this will place a great strain on relationships between the foster mother and the real mother and hence be harmful to the child too.

Those in favour of the technique would argue that in some situations a woman might well be prepared to foster another's child in this way and provided she is mature about the situation and enters it well informed, the process need not be too traumatic.

THE RELATIONSHIPS BETWEEN REAL MOTHER AND CHILD : Many have claimed that the foundation for a relationship between mother and child is laid during the period of pregnancy when basic hormonal changes take place to prepare the mother for rearing children. They use this argument to oppose embryo transfer on the grounds that it contradicts the natural process of childbirth and rearing.

The argument may be countered by those who claim that the relationship is obviously one which the real mother is keen to have and is prepared for. So the problems arising are similar to those of people wishing to adopt a child, and probably less complex, because the child produced is basically that of the parents.

CONCLUSIONS : What conclusions can we draw about the manipulation of fertility? As the two processes are at different stages of development they provide different problems. But both have implications for the kind of society in which we want to live and the relationships within that society. They raise fundamental questions about the nature of family life. What place does the raising of children have in a marriage? What value should we place on the bringing up of children by their natural parents? Does this raise different questions from those raised by adoption?

The debate about the issues is perhaps less far-flung and less complex than that on abortion. Nevertheless the questions raised are as important and their importance will not decrease.

F O R D I S C U S S I O N

1. "We should control fertility research very carefully because women anxious to have children can be easily exploited by those who are only interested in their own scientific advance".
   Do you agree? How should women be protected?

2. "Our only concern in this question should be the quality of life that future children will have".
   Is this true? Are other considerations important?

3. "Future research has within it the potential for creating enormous happiness for women who might have borne the stigma for being childless".
   Is there too much emphasis placed on the importance of children in marriage?

4. "To accept AID too readily is to undermine the traditional concept of family life." Why do you think people put forward this argument? How do attitudes to the family affect moral decisions which might be made about AID?

5. In June 1977 it was reported that a woman gave birth to a child through AIH after her husband had been dead 17 months. What ethical implications do you see for a) The mother and b) The Child?

CARE OF THE DYING

The advances in medical science have caused us to review our concepts of death. In the past 20 or so years the possibilities of keeping people alive have been greatly advanced, but recently a large number of people have questioned whether to be kept alive is a value in itself. So the problems created by this situation are both medical and moral.

THE MEDICAL ISSUE : In the medical world there is a continuing debate about what constitutes death. Traditionally death was thought to take place when the vital organs of the body (e.g. the heart) ceased to function but in recent times it has been redefined in terms of "brain death", i.e. when no electrical activity can be identified in the brain.

THE ETHICAL ISSUE : The medical/scientific debate about the moment of death continues: but there are moral and religious questions to be asked about the meaning of death and suffering and the perspective this puts on life.

Some philosophers such as Camus in his book "The Plague" might suggest that the fact of death negates the meaning of life. Since all life ends in death, life itself has no meaning.

The Buddhist tradition suggests that suffering is an inevitable part of life, but that men may be relieved of the pain of the world and rendered immune to its frustration by following the eight fold path.

The Christian tradition suggests that death and suffering can be faced and lived through. Death becomes part of life as affirmed in the doctrine of resurrection. Suffering can be a creative force in the development of individual charactor. This should not suggest that one should encourage suffering for its own sake, but rather that suffering can be a creative, deepening process and give us more understanding of life.

One's view of death and suffering may affect one's attitude towards the care of the dying. However, many people of different religions and philosophies would agree that a patient has a right to be well cared for until he dies, and that dying should be peaceful rather than anguished.

In 1969 an unsuccessful motion was put to Parliament to suggest that euthanasia should be legalised.

Strictly speaking 'euthanasia' is translated as a "good death". Those who advocate it would support its legalisation with statements such as : "We are not cranks, we simply do not want ourselves or our friends to be preserved as vegetable specimens, a triumph of medical techniques. We do want our deaths to be as comfortable and happy as possible."

A central question in this particular issue is "What does it mean to die with dignity?"

MORAL PROBLEMS : So far those who oppose euthanasia and many of those who are for it, would probably be in agreement. Few would advocate treating a patient harshly and although no one minimises the strains put on a doctor in this situation, many would suggest that trust and compassion should be the guidelines for caring for the dying. But moral problems mount when patients actually wish to die, or when it is felt that people are being kept alive only by miracles of technology or use of drugs. A central theological debate arises around the meaning of life and our attitude to suffering. If one feels that life is a gift to be preserved, that all suffering can be creative one might oppose euthanasia; if one feels that men have been given the freedom to end their own lives if they should wish to, that there is no point in living life without purpose and dignity, then one might well advocate it.

In this situation there are two major questions to be asked:

"Who has the right to decide a patient should die?"
"On what criteria should one make that decision?"

To the first question the answer given by those who are for euthanasia is, unquestionably, the patient himself. But this is countered by those who point out that many patients may change their mind about such a decision when they have adjusted to the fact of death.

The second question, however, is still more problematic. Should the decision to die be because one is a "vegetable", because one can "no longer contribute to society", because one "is a trouble to friends and relations", or because one is "in such pain that to live is no longer worthwhile". Obviously few would wish anyone to continue to live in extreme pain and to this end pain-killing drugs can be used with care. Two major strands to the pro-euthanasia argument are - firstly that no one wishes more suffering on their close relations and friends than necessary, and secondly that people ought to be allowed to die in peace despite the ease with which they could be kept alive as a medical specimen. Those opposing euthanasia might well point to the potential pressures placed on a doctor by selfish friends and relations and say that medicine should be concerned with preserving life rather than destroying it.

Dying with dignity involves treating patients with respect and being willing to discuss their situation with them. Several writers on the subject have stressed the importance of trust between doctor and patient and many have said that to shield the truth from patients may destroy this trust. Ultimately the situation is one which depends very much on the individual for some may be more able to cope with death than others. However, very few would condone any deliberate deception of the patient, and many writers have stressed the importance of inter-personal trust and communication on the matter.

Given the trust and honesty between doctor and patient, how does this affect someone's treatment? Dr. Cicely Saunders, who is the director of a hospital for terminal care, suggests that the family should be involved in looking after patients as much as possible, and as far as possible physical and mental stress should be relieved using drugs available.

Euthanasia may take two forms - "passive", in which death is permitted, and further attempts to keep patients alive are abandoned, and "active" in which death is caused in situations where patients are in such a distressed state that they no longer wish to live.

Can we make any distinction between these two sorts of euthanasia? It has been argued that one can well do so. The permitting of death is one in which one does not actively prolong life; "active" euthanasia is one in which one may actually give a patient drugs to end his or her life.

Discussion on the question continues at length. Meanwhile every day doctors and nurses are faced with life and death decisions made more difficult by modern techniques. Many on both sides of the question agree that the situation is very often a highly individual one and judgment should be based on compassion and respect for the patient's interest rather than legal sanctions and rules only.

FOR DISCUSSION

1. "Does one want to go down in the memory of one's descendents as a cheerful imbecile?" Is such a description an accurate statement about some old people? If so, would it merit the introduction of euthanasia?

2. "Euthanasia should protect people from useless torture". Do you feel there can be any value in human suffering? Or should it be avoided at all cost?

3. "In situations of respect and compassion euthanasia would be unnecessary. We should improve facilities for caring for the dying, rather than offer it as an easy way out". Do you agree and how does this relate to your attitude to suffering?

4. "No one has a right to take away life". Is this always true? If you think not, in what circumstances might it be untrue? And what problems would it pose for (a) the person who decided to take away life, and (b) the person whose duty it was to do so?

5. One Catholic theologian opposed to euthanasia stated, "Man ends his life as he began it, and this return to childhood is in some measure the natural curve of human existence". Do you feel that we should respect his natural curve above all else? What arguments can you think of for and against this position and how does it affect your view of euthanasia?

QUALITY OF LIFE

The doctor/medical scientist is obviously not only concerned for the birth and death of his patients, he is also concerned about their physical health and their resulting quality of life.

There are many causes of illhealth. The body may suffer an accident or injury or it may be subject to an inadequate food supply resulting in malnutrition. It may be infected by agents from outside the body, such as bacteria or viruses, or its own genetic components may cause it to function inefficiently.

Treatment of disease takes various forms. Much progress has been made in developing anti-biotics and anti-viral agents which combat the effects of bacteria and viruses respectively. Malnutrition amongst many sections of the populace in Britain has been greatly reduced and the doctors' capacity to treat accidents and injuries has increased with the development of medical and surgical techniques. It is outside the scope of this PROBE to investigate in detail all the ethical problems in connection with these areas, so two examples have been selected for more detailed discussion.

As one example we have considered organ transplants. Recent advances in transplant surgery raise new questions about life and death which have been widely publicised and hotly debated.

As another example, we will consider recent advances in medical genetics - a subject which is increasingly likely to affect our future quality of life. Genetics is the study of biological characteristics which may be passed from parent to child through vehicles of inheritance - the genes. Medical genetics is concerned both with the genes which cause "undesirable" characteristics and illhealth, (e.g. haemophilia), and with aberration in the whole genetic apparatus which may cause features such as mongolism. Recent genetic research has suggested that we may be able to increase our control over such characteristics, and this has raised ethical questions of its own. As one writer has put it, "Today is the age of transplant surgery, tomorrow the age of genetic control".

Organ Transplant

On 3rd December 1967, Dr. Christian Barnard opened up a new era in medicine by performing the first surgically successful heart transplant. Between then and June 1970, 160 heart transplants were carried out; of these only 10 recipients had survived at that time.

In the area of organ transplant, we are concerned mainly with the heart and the kidney; at present these are most commonly transplanted organs. However, the situations surrounding transplant differ: if the heart fails, patients die; but if both kidneys fail, kidney dialysis techniques may be used.

The main difficulty in transplant surgery is the reaction of the body to the transplanted organ. The human body has a defence system in its white blood cells which act chemically and physically to destroy any foreign body invading it. The cells cannot distinguish between a body likely to cause infection and that which will give it new life, - e.g. the transplanted heart or kidney. The discovery of drugs which will suppress this "immune reaction" has meant that the rejection of a foreign heart/kidney can be combatted.

There are three main reasons why this raises new ethical questions: firstly because the process is in an experimental stage and not yet guaranteed successful. Secondly because it increases the possibilities of extending life further and thus may alter classical conceptions of death (which at one time was defined as when the body's vital organs, e.g. the heart, would no longer function effectively). Thirdly and most important, because it impinges on the question, "What is the aim of medicine?".

ETHICAL PROBLEMS : The ethical problems that this raises are several and relate both to the donor and the recipient.

FOR THE DONOR : In the case of the kidney transplants, there are three types of people who may be able to donate organs - living donors - either related or unrelated, or those who have just died - cadaver donors. (Naturally, all transplants of hearts are from the latter type.)

Central to the problem are two questions :

1. If the donor is alive, how will his life be jeopardised by the removal of a kidney?

2. How can a living donor be guaranteed to give "free informed consent" on the matter of transplant, particularly if he is related to the patient?

Those opposing kidney transplantation might argue that one cannot justify any maiming of one person in the name of medicine, and that the recipient is potentially open to being exploited by emotional pressures.

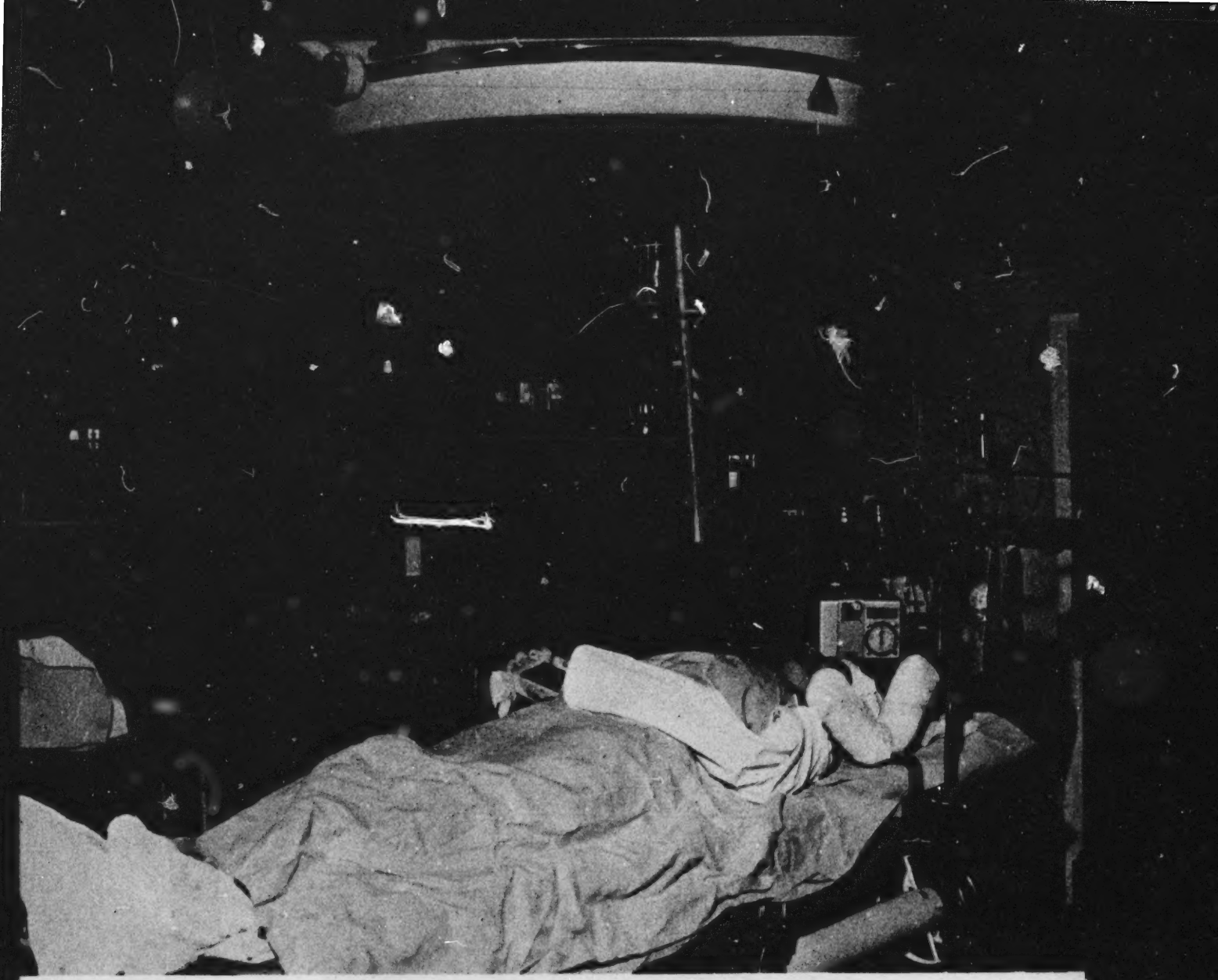
Those in favour might suggest that the expression "maiming" might be somewhat strong; the statistical risk of the donor's second kidney failing is 0.5%. Safeguards within the hospitals to refuse volunteers on health grounds might relieve the pressures on the donor. Certainly these problems are lessened using cadaver donors. At present it is possible to carry a card indicating one is willing to be a kidney donor in the event of sudden death. This means that an individual is able to decide whether or not he is willing to donate an organ for transplant away from situations of emotional stress and although relations must be contacted, it reduces difficulties in approaching them in distressing circumstances.

The central problem for the doctor hinges on diagnosing death, and the World Medical Association principles state that this diagnosis must be independent of transplant considerations.

THE RECIPIENT : Ethical questions concerning the recipient are somewhat different. They relate to the question of who should be

21

A kidney machine in use. This one cost £3,500 several years ago.



The first kidney transplant in Hungary.

chosen to receive transplants, and to effects of transplants on those who receive them.

In her book, "Organ Transplants - the moral issues", Catherine Lyons writes that the medical profession has a duty to people regardless of their social worth or status. It relates to them in terms of what their needs are rather than what they can give society.

She states 4 guidelines for choosing whether or not someone should qualify medically as a candidate to receive a transplant: firstly that the person

should be in critical need of an organ, but secondly that he should at the same time be well enough to undergo the physical and psychological strains of the operation. Thirdly that the disease which caused the destruction of the first organ should be borne in mind - as it may destroy a second. Fourthly that one should examine the complicating factors of the patient's condition which could hinder recovery.

At present there are more people medically qualified to receive organs than organs available and thus the question of selection for transplant is important. Should one select by lot, or by considering which potential recipient has greatest chance of survival? Should one consider the contribution a patient might make to society? Or should one consider the contribution of the operation to the advancement of medicine?

Secondly, one should consider the effects of the transplant on the individual undergoing the operation. The drugs administered to a patient in the process may have considerable side-effects. It has been reported that patients can be psychologically affected by drugs - for instance one fortyfive year old man after receiving a heart from a twenty year old donor announced the celebration of his twentieth birthday. Is medical science justified in using drugs which will heal someone physically but harm the patient mentally?

Those who oppose transplants will argue that we have no right to "cost people's lives" by selecting only a few for such an operation. They may say that the dignity of a patient's life is threatened by the effects of the drugs and that the process is too open still to abusing the individual for the advancement of medicine.

Those in favour of transplants will argue that potentially the operation is a life-saver and that while the situation is still at an early stage it is impossible to give everyone the benefit of the treatment. Medicine must be interested in its own advancement if it is to continue to act as a servant to those who require its aid.

Providing patients are able to participate in decision making and are adequately informed of the consequences, much fear of abusing patients for scientific advance may be overcome.

F O R D I S C U S S I O N

1. "We have done nothing to heal a man if we save his physical state at the expense of his mental capacity".
   Have we really cured someone if he is physically but not mentally healthy?

2. "We should develop a system where people opt out of transplants rather than opt into them".
   What does this mean in practice? Do you feel this idea abuses individual freedom?

3. "Heart transplants are too often prestige experiments carried out for the benefit of the doctor's reputation rather than the patient's good".
   Is this true? Does it matter and why?

4. "Transplants place too much responsibility in the hands of doctors who may have to chose between patients in need".
   Do you feel there is a danger that organ transplant will create a situation of preferential treatment among patients?

5. In June 1977 it was reported that Dr. Christian Barnard assisted a woman's heart by adding to her circulatory system a heart taken from a baboon. What moral implications do you see in this operation? What questions do you think it raises for our view of man/woman in society?

Genetic Control

INTRODUCTION : Progress in medical techniques has lowered the mortality rate in the world population and preserved many lives which formerly would have been lost. But what consequences has this had? The effects have been quantitative - more people have lived longer than they used to: and qualitative - we have an ability to keep alive who previously would not have been fit to survive. The "quality" of a population is directly related to its genetic make-up.

Geneticists may analyse individuals by considering their genetic make-up (genotype) and the environment in which the genotype exists. The interaction between different genetic components of an individual and between these and his environment determine his quality of life. Individuals who were genetically capable of surviving in a given environment lived on and reproduced - those who were not did not survive. This process of "natural selection" forms the basis of evolution - Darwin's theory of survival of the fittest.

This does not imply that the population who survived were all the same - for any environment can sustain considerable genetic variation: it does imply that those who survived were able to fend for themselves, and not dependent on a specialised environment.

With improvement in postnatal care, babies who possess genes which formerly would have been lethal, have survived. To give one example, some children are born with a gene which renders them unable to use the sugar galactose and are "galactosemic": this disease shows symptoms of an enlarged liver and retarded mental development and results in death. Now these children may be fed on a specialised diet which means that they can survive.

Among some philosophers, concern has been expressed about this situation. Within the population as a whole, genes have survived which can be classified as "inferior" - e.g. those causing "galactosemia". When individuals reproduce these genes may be passed onto their children and succeeding generations in the population as a whole. Some have called for improving the "genetic health" of the population, either by the process of "eugenics" or by "genetic engineering".

EUGENICS : This is a process in which artificial selection of genes takes place - either by selecting against "negative" genes or selecting for "positive" ones.

Negative eugenics is a process in which harmful genes in the population are destroyed - mainly by persuading inviduals who carry them not to reproduce. Couples who have produced a child with a genetic illness, or who have a family history of genetic illness may consult qualified practitioners. These genetic counsellors may give advice about the chances of producing further children with the illness, and the couple may decide themselves not to produce children if the chances are high. At present this is not widely practised, but surveys in the areas where it has been carried out have shown that couples consulting a counsellor have been helped to understand these risks involved and have taken action accordingly.

A SWEDISH MATERNITY HOSPITAL

Does it suggest the selective breeding of Aldous Huxley's "Brave New World"?

Perhaps a more debatable scheme of negative eugenics takes place in Denmark, where mentally defective people are sterilised to prevent any genetic factors in their illness being passed on to the next generation.

"Positive eugenics" is a system in which individuals are selectively bred for "good" genetic characteristics - and it is possible to envisage embryo transfer and artificial insemination being adapted to this end.

"GENETIC ENGINEERING" : This is a process in which the genetic message itself is manipulated (e.g. the gene causing, for instance, blue eyes could be altered to one causing brown eyes).

Many geneticists have claimed that it would be almost impossible to adapt this in the human situation, although research into the possibilities of directly altering genes in more simple organisms continues to advance.

ETHICAL QUESTIONS : Here one is faced with many ethical questions, which centre around the question of the individual in society. Many who oppose such advances will point out the real dangers of these techniques being politically manipulated. How is one to maintain a respect for life if these kind of techniques are adopted as a social programme? Who is to decide what are desirable genetic characteristics and what are undesirable? What effect could they have on the freedom of individuals in a society to reproduce and has anyone the right to take away that freedom?

While respecting these very real dangers, others might argue that some applications of this research are potentially good and of value in individual situations - such as the prevention of couples producing mongol children, and the removal of guilt feelings which any couple might have about this. Perhaps as long as science is the servant, rather than the master of ordinary people, genetic manipulation could make a valuable contribution to our society as a whole, and to individuals within it.

F O R D I S C U S S I O N

1. "Eugenics is a serious threat to family life today".
   Need it be?

2. "We should be more concerned about the genetic composition of the population as a whole than the right of the individual to reproduce".
   Do you agree, or do you think this is open to abuse?

3. "Genetic manipulation of the population is politically extremely dangerous".
   Why should this be so?

THE HIPPOCRATIC OATH

I SWEAR BY APOLLO THE HEALER, INVOKING ALL THE GODS AND GODDESSES TO BE MY WITNESSES, THAT I WILL FULFIL THIS OATH AND THIS WRITTEN COVENANT TO THE BEST OF MY ABILITY AND JUDGEMENT.

I WILL LOOK UPON HIM WHO SHALL HAVE TAUGHT ME THIS ART EVEN AS ONE OF MY OWN PARENTS. I WILL SHARE MY SUBSTANCE WITH HIM AND I WILL SUPPLY HIS NECESSITIES IF HE BE IN NEED. I WILL REGARD HIS OFFSPRING EVEN AS MY OWN BRETHREN, AND I WILL TEACH THEM THIS ART, IF THEY WOULD LEARN IT, WITHOUT FEE OR COVENANT. I WILL IMPART THIS ART BY PRECEPT, BY LECTURE AND BY EVERY MODE OF TEACHING, NOT ONLY TO MY OWN SONS BUT TO THE SONS OF HIM WHO TAUGHT ME AND TO DISCIPLES BOUND BY COVENANT & OATH, ACCORDING TO THE LAW OF MEDICINE.

THE REGIMEN I ADOPT SHALL BE FOR THE BENEFIT OF THE PATIENTS ACCORDING TO MY ABILITY & JUDGEMENT, AND NOT FOR THEIR HURT OR FOR ANY WRONG. I WILL GIVE NO DEADLY DRUG TO ANY, THOUGH IT BE ASKED OF ME, AND ESPECIALLY I WILL NOT AID A WOMAN TO PROCURE AN ABORTION. WHATSOEVER HOUSE I ENTER, THERE WILL I GO FOR THE BENEFIT OF THE SICK, REFRAINING FROM ALL WRONGDOING OR CORRUPTION AND ESPECIALLY FROM ANY ACT OF SEDUCTION, OF MALE OR FEMALE, OF BOND OR FREE. WHATSOEVER THING I SEE OR HEAR CONCERNING THE LIFE OF MEN, IN MY ATTENDANCE ON THE SICK OR EVEN APART THEREFROM, WHICH OUGHT NOT TO BE NOISED ABROAD, I WILL KEEP SILENCE THEREON, COUNTING SUCH THINGS TO BE AS SACRED SECRETS. PURE & HOLY WILL I KEEP MY LIFE & MY ART.

IF I FULFIL THIS OATH AND CONFOUND IT NOT, BE IT MINE TO ENJOY LIFE & ART ALIKE, WITH GOOD REPUTE AMONG ALL MEN AT ALL TIMES. IF I TRANSGRESS & VIOLATE MY OATH, MAY THE REVERSE BE MY LOT.

MEDICINE IN SOCIETY

Not only have advances in science caused changes in medicine, its place in society has changed too.

1. What is medicine for?
2. Has medicine stopped us helping ourselves?
3. How is money best spent?

are three questions we should consider.

WHAT IS MEDICINE FOR? : The role of the doctor and that of medicine in society cannot be seen in isolation from the values held by society itself. The fact that in Britain we spend a large part of our national budget on the national health service, suggests that we value the medical profession highly and that medical care is an integral part of our society.

Over the past fifty years, research has increased the scope of medicine enormously. We have the possibility of manipulating life and death - of prolonging life or ending it at will. Such possibilities have made the doctor's job far more complex: and have changed the expectations of those in our society about health care.

In the context of this complexity practioners of medicine may find themselves grappling with questions such as "How are we contributing to the health of the community as a whole?" "Is there any value in suffering?" "Should life be prolonged at all costs?" "What is our attitude to death?" It is when one considers more fundamental questions such as these that one grasps many of the implications of the question "What is medicine for?"

HAS MEDICINE STOPPED US HELPING OURSELVES? : No longer is health the prerogative of those who may pay for a doctor; as in most countries medical assistance has become government aided. Health is now a human right.

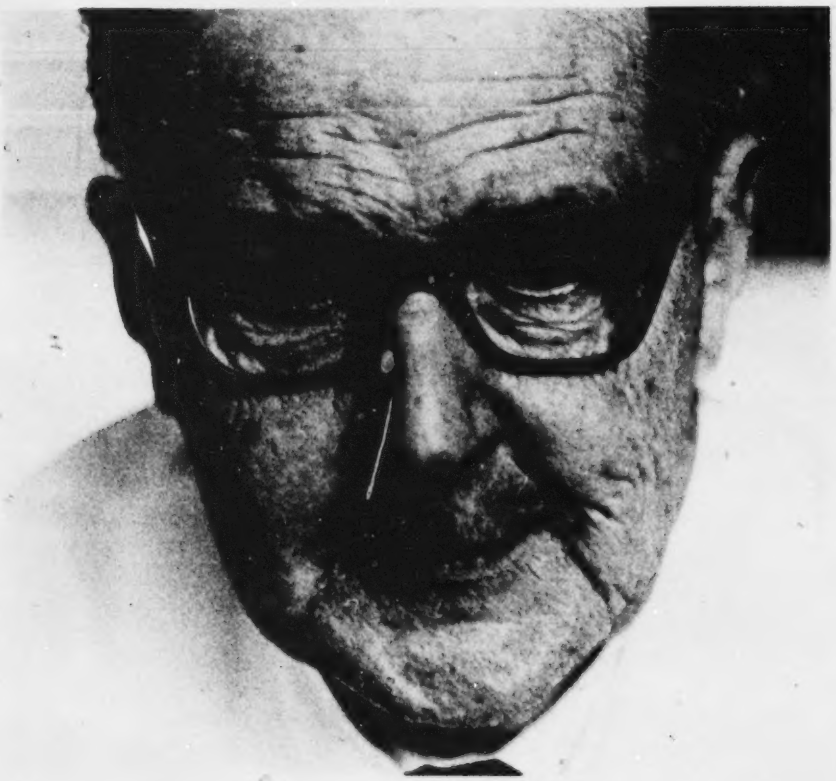
But ironically this progressive step may have a negative side. In his book "Medical Nemesis", Ivan Illich radically criticises the professionalisation of medicine. Illich suggests that, with the increase in medical care provided by the state, people have become less responsible for their own health and more dependent on impersonal services. Has modern medicine taken away responsibility from the individual?

Further he suggests that the expansion of the drug industry may well have poisoned many people - drugs may be addictive, mutilating or may contribute to the breeding of drug-resistant strains of bacteria. Has modern medicine damaged the health of the community as a whole?

HOW IS MONEY BEST SPENT? : Bearing the above questions in mind, society is still faced with the question, "How do we distribute limited resources?". Recent strikes by members of the medical profession drew attention to the financial needs and job conditions of many junior doctors.

Should one attempt to staff the profession adequately and pay it well? Should one alternatively develop technology so that fewer people should be employed in various aspects of the medical profession? What proportion of money should be spent on research and development of techniques? And finally how does our spending on medicine relate to that on education and other aspects of government spending?

It is when we consider these practical questions that we are faced with deeper issues relating to the dignity of both doctor and patient, the possible depersonalisation of medicine and the value and meaning of health in society at large.



DIFFICULT DECISION - WHO DECIDES? AND HOW?

FOR RESEARCH

1. Some have claimed that medicine spends too much on prestige experiments and not enough on preventative care.

   Can you find out how resources within the profession are distributed?

2. Ask a local nurse to come and talk on the subject, "Fair pay for Nurses" in the context of money in the profession as a whole.

3. "Twenty years ago, granny would have cured this".

   Ask your local G.P. if he feels that we are too dependent on the health service. And if too many people come to him with diseases which could be cured at home.

4. "There is no point in curing an elderly patient of pneumonia to send her home to a damp house".

   Try to find out from several people involved in caring for the elderly, how they see social conditions interacting with medical ones to cause illhealth.

A MATTER OF CHOICE

In this complex situation, how do doctors decide how to act?

What principles, codes or guidelines do they relate to?

A MATTER OF TECHNICAL SKILL? : Some may wish to reduce the question of 'right' and 'wrong' to that of 'technical skill'. "If it's possible to keep a patient alive, we will do so". Several arguments may be levelled against this approach.

Firstly, medical advances are not always infallible - heart transplants for instance, are certainly not guaranteed to keep the patient alive for ever. Secondly, medical care costs money and our resources are limited, (e.g. kidney dialysis machines are not available for all who may benefit from them. Thirdly, and possibly most important, it may not always be in the patient's best interest to remain alive and in pain indefinitely - the question of technical skill may become more important than that of the interest of the patient.

Clearly then we need some other criteria for helping us understand the complexities of moral judgment. The formal study of morality is known as 'Ethics'. Ethicists attempt to move objectively from descriptions of particular situations to analyse universal principles and concepts relating to moral behaviour.

THE ESTABLISHED CODES : For 2,400 years doctors have based their principles on the Oath of Hippocrates, which was revised and adopted by the World Medical Association in 1949. You may read the full text on page 31. Nurses are asked to adhere to the International Code of Nursing Ethics adopted by the International Council of Nurses in 1953 and revised in 1965.

Despite the establishment of such codes, those in the profession are still faced with making moral choices. Firstly, because the codes themselves may contain hidden inconsistencies; secondly, because when applied to a specific situation statements of general principle may not be adequate to meet its complexities.

To illustrate the hidden inconsistencies of the codes, we can look at the first clause of the Nursing Cod which states that the fundamental responsibility of the nurse is threefold - "to conserve life, alleviate suffering and promote health". But in many situations these responsibilities cannot be met simultaneously.

An example to illustrate this is the case of a man in considerable pain who will eventually die. Should one alleviate his suffering and allow him to die? Or should one preserve his life and allow him to suffer?

The example above also illustrates our second major point, that choices which face the medical profession are often extremely complex. The basis of the oaths which doctors and nurses take may be summed up as "service to mankind"

THE GENEVA CONVENTION CODE of Medical Ethics: Adopted by the World Medical Association in 1949.

I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;

I will practice my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets which are confided in me;

I will maintain by all the means in my power, the honour and noble traditions of the medical profession;

My colleagues will be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honour.

and allied to this "respect for human life". But how can these be best applied in each situation?

CAN OTHER GUIDELINES HELP? : In his book, MORAL DILEMMAS IN MEDICINE, Dr. Alastair Campbell suggests that there may be 4 guidelines which may help individuals to make a wise decision about the morality of their actions :

- individual conscience
- the common good
- rules and situations
- respect for persons

To simplify an extremely complex argument it is claimed that the norm of 'respect for persons' is the one most suited to solving moral dilemmas in medicine. Decisions based on an individual's conscience may create great dissent in the profession and between doctor and patient; while the 'common good' theory can lead to abuse of an individual patient's rights for the cause of society and the treatment of patients as "guineapigs" in the advancement of science. It may be impossible to relate a set of rules to complex specific situations, and in addition the formal nature of rules may remove personal responsibility in moral decision.

The concept of 'respect for persons' although not totally foolproof, implies firstly that no final authority is put on a set of rules, but that decisions are made in the light of specific personal situations; "What is best for the patient?" is the guiding question. Secondly, in taking the decision doctors should have a feeling of "fellow-humanity" with patients and acknowledge their capacity to take decisions about their own lives; decisions are thus taken jointly rather than singly. Finally, it implies that the value of the individual is greater than that of society; no amount of "technical progress" or "common good" justifies the depersonalising of individuals.

FOR RESEARCH

1. Find out whether committees in your local hospital are set up to look at ethical questions. How are they made up?
2. Ethics is the name for the study of moral issues in general. Find out more about this subject. (A good place to start is the C.E.M. booklet - ETHICS by Michael Hinton.)

CONCLUSIONS

It is almost impossible in a publication of this kind to come to conclusions - but it is relevant here to look at some basic ethical questions with which we are dealing.

In discussion, several points have continually arisen :

1. The question of decision-making. Who has the right to decide about a patient's well-being? Should the decision be up to the patient, the doctor, or both?

2. What should inform our decisions? Is the criterion 'respect for persons' too subjective? In situations of choice, (such as between a mother and a foetus,) who deserves more respect?

3. How do the interests of the individual relate to those of society? Are there ever situations in which the former should be sacrificed for the latter?

4. How should medicine as a whole "progress"? On what should it choose to spend its money in a situation of limited resources? Should we invest in technological advance, e.g. heart transplants, at the expense of other services, or hospitals at the expense of clinics?

5. What does the institutionalisation of medicine imply for the responsibility of the individual? Have we lost touch with our "humanness" in handing over responsibility for our own suffering to a professional group of people? Or is this the only way in which all may have the opportunity of health?

All these are vital questions for the medical profession as a whole, but very often they relate too to society at large. "Why," said one doctor, "are people always talking about medical ethics? Ethics should to all of society."

The question of ethics certainly relates to the way in which we feel people should behave towards each other, not only in situations of suffering but in other situations too, and all the basic questions asked in this chapter can be applied to other areas of life.

Finally, it is relevant to ask what our medical situation means in a world context? In the U.K. one doctor is available for 800 people, in India one for 8,000 and in Tanzania one for 22,000. Mortality rates in the developing Third World may be 10 times as high as those in Britain and obviously health problems there are far worse than they are over here. Solutions to their problems may be different, such as the Chinese barefoot doctor system by which teams of people are trained in elementary health care, but they put British problems into a context which challenges many of us to look closely at our own values and priorities.

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1. Social Concern & Biological Advances - study group report of the British Association for the Advancement of Science 1974.
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2. The Problem of Euthanasia - proceedings of a Conference held at The Royal College of Physicians by the London Medical Group & the Society for the Study of Medical Ethics.
3. Euthanasia, a Methodist Statement - The Methodist Church Division of Social Responsibility.

Dying - John Hinton - Pelican.
Church of England Board of Social Responsibility - On Dying Well.

Some other books/publications & addresses for further reading or stimulating discussion.

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Life ; 35 Kenilworth Road, Leamington Spa, Warwicks.
Abortion Law Reform Association - 186 Kings Cross Road, London WC1 9DE
The Silence is Broken - Risk No. 13 Vol. 1. W.C.C.
Concord Films - Phoebe.

Genetics :
Brave New World - Aldous Huxley.

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The Plague - Camus.
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Surprised by Joy/Grief Observed - C.S. Lewis.

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Organ Transplants :
Looking at my Heart - Blaiberg - Heineman.

Medicine in Society :
Health - Roy Billington - C.E.M. PROBE

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